STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157243	A. BUILDING _____ B. WING _____	R 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH FORCE OF INDIANA	**334 N ENTERPRISE DR WARSAW, IN 46580**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS	{G 000}		

This revisit was for an extended federal home health recertification survey that was conducted on October 15-17 and 20-21, 2014.

Survey Date: December 1, 2014

Facility #: IN005836

Medicaid #: 200118810A

Surveyor: Tonya Tucker, RN, PHNS

Three (3) Conditions and 17 standard level deficiencies were found to be in compliance during this survey.

Health Force of Indiana is in compliance with the Conditions of Participation 42 CFR Part 484 for Home Health Agencies.

Health Force of Indiana is precluded from providing its own training and competency evaluation program for a period of 2 years beginning October 21, 2014, - October 21, 2016, for being out of compliance with the Conditions of Participation 484.18: Acceptance of Patients, Plan of Care, Medical Supervision; 484.30: Skilled Nursing Services; and 484.32: Therapy Services.

Current Active Patients: 78

Quality Review: Joyce Elder, MSN, BSN, RN
December 2, 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE